Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDI-PLUS PHARMACY
PO BOX 546
BARKER TX 77413

Respondent Name

TEXAS MUTUAL INSURANCE CO.

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1082-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Reduction of claims due to (CAC-W10) 'No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.' – Texas Mutual has determined that there is no maximum allowable reimbursement (MAR) for prescription medication and that it can pay a fair and reasonable amount based on its estimation of what is Usual and Customary in the market. **Texas Mutual has not provided any documentation to date to show how it determined Usual and Customary or what its reported 'research' showed, much less how it determined fair and reasonable. Division Rule 134.503 provides that the MAR is the lesser of the provider's usual and customary charge or the amount determined by a formula provided in 134.503(a)(2).** (517) 'Paid at est. U&C based on research, labor code sec. 413.043 and 2002 PFG, 29 Tex-Admin Code 132.503' – The pharmacy's U&C charge is the amount it normally charges the walk-in customers that have no insurance or are covered by private health insurance. Most pharmacies participate in networks in which compensation is governed by contract for transactions subject to such contracts. We do not belong to any PBM or are not contracted with any private Insurance. Medi-Plus Pharmacy has set out to function under a unique situation that is not considered under Texas Mutual so called study of the norm U&C fee for pharmacies…**Medi-Plus pharmacy on the other hand has no merchandise to profit from but gives specific service related to workers' comp. patient.**"

Amount in Dispute: $139.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent did not submit a response to the request for Medical Fee Dispute Resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
January 31, 2011 and February 23, 2011	CYCLOBENZAPRINE VOLTAREN HYDROCODONE	$139.96	$139.96
	TOTAL	$139.96	$139.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §401.011(22) defines "health care provider" as a "health care facility" or "health care practitioner."
3. Texas Labor Code §401.011(19)(E) defines "health care" to include a prescription drug, medicine, or other remedy.
4. Texas Labor Code §401.011(20) defines "health care facility" as a hospital, emergency clinic, outpatient clinic, or other facility providing health care.
5. 28 Texas Administrative Code §134.503, adopted to be effective January 3, 2002; amended to be effective March 14, 2004, set out the reimbursement guidelines for pharmaceutical services applicable to this dispute and is the version used throughout this decision.
6. 28 Texas Administrative Code §133.20, titled *Medical Bill Submission by Health Care Provider,* sets out the billing requirements.
7. The services in dispute were reduced/denied by the respondent with the following reason codes: for dates of service:
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 517 – Paid at est. U&C based on research, Labor Code Sec 413.043, and PFG, 28 Tex: Admin Code 134.503.
   - 862 – Paid at fair & reasonable because there is no evidence the provider has billed in accordance with Rule 133.20(E).
   - 891 – No additional payment after reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Were all the services in dispute filed in the form and manner prescribed by the division?
2. Is Medi-Plus Pharmacy a health care provider?
3. Did the requestor establish the unusual and customary charge for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This medical fee dispute was filed on December 8, 2011. The dates of service in dispute are from January 31, 2011 and February 23, 2011; therefore, the requestor has met the requirements of 28 Texas Administrative Code §133.307(c) and the dates of service are eligible for review.

2. Review of the documentation submitted finds that Medi-Plus Pharmacy, the requestor in this medical fee dispute, is the health care provider because it is a health care facility as defined by the Texas Labor Code.

3. As stated above, the health care provider is Medi-Plus Pharmacy. Medi-Plus Pharmacy submitted numerous examples of amounts billed to workers' compensation carriers other than the respondent. In its review of these

billing examples, the division noted amounts billed for pharmaceuticals that were the same or similar to those in dispute, and whether the dates of service were reasonably near the dates of service in dispute. Comparison of the billing examples to the medical bills, or DWC-66 forms, for the services in dispute supports that Medi-Plus Pharmacy billed its usual and customary charges to Texas Mutual Insurance Company for CYCLOBENZAPRINE 10MG TAB (60 Units); VOLTAREN 1% GEL (500 Units) and HYDROCOD/APAP 10/650 TAB (30), for the dates of service January 31, 2011 and February 23, 2011.

4. 28 Texas Administrative Code §134.503(a) states that "The maximum allowable reimbursement (MAR) for prescription drugs shall be the lesser of:
   (1) The provider's usual and customary charge for the same or similar service;
   (2) The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed.
      (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = MAR;
      (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee = MAR;
      (C) A compounding fee of $15 per compound shall be added for compound drugs; or
   (3) a negotiated or contract amount.

   28 Texas Administrative Code §134.503(a)(1) is established by determining the provider's usual and customary charge. Therefore, the billed amounts represent §134.503(a)(1) for each disputed drug.

   The AWP formula described in 28 Texas Administrative Code §134.503(a)(2) is based on the average wholesale price determined by a nationally recognized pharmaceutical reimbursement system. Medi-Plus Pharmacy provided documentation in its request for dispute resolution to support that it utilized First Data Bank's AWPs, specific by NDC, to calculate the disputed pharmaceutical's AWP formula amounts. The respondent did not provide documentation to sufficiently support that it calculated its own AWP formula amount, nor did it submit information regarding what, if any, nationally recognized pharmaceutical reimbursement system it may have used to calculate §134.503(a)(2).Consequently, the AWPs supported by Medi-Plus Pharmacy are appropriate for calculating the AWP formula pursuant to §134.503(a)(2).

   28 Texas Administrative Code §134.503(a)(3) is described as a "negotiated or contract amount." Documentation submitted by both the requestor and respondent supports that no contract exists between Texas Mutual Insurance Company and Medi-Plus Pharmacy.

   The maximum allowable reimbursement (MAR) is therefore determined by establishing the lesser of §§134.503(a)(1) and (a)(2) as follows:

Dates of Service	Prescription Drug	§134.503 (a) (1)	§134.503 (a) (2)	MAR is lesser of (a)(1) and (a)(2)	Carrier Paid	Due
January 31, 2011	CYCLOBENZ-APRINE 59746017710	$86.50	((1.1 x 60) x 1.25) + $4.00 = $86.50	$86.50	$53.00	$33.50
January 31, 2011	VOLTAREN 634810684	$176.00	((0.3156 x 500) x 1.09) + $4.00 = $176.00	$176.00	$166.41	$9.59
January 31, 2011	HYDROCODONE 00591050305	$38.10	((0.90933 x 30) x 1.25) + $4.00 = $38.10	$38.10	$23.96	$14.14
February 23, 2011	CYCLOBENZ-APRINE 59746017710	$86.50	((1.1 x 60) x 1.25) + $4.00 = $86.50	$86.50	$53.00	$33.50
February 23, 2011	VOLTAREN 634810684	$201.50	((0.3624 x 500) x 1.09) + $4.00 = $201.51	$201.50	$166.41	$35.09
February 23, 2011	HYDROCODONE 00591050305	$38.10	((0.90933 x 30) x 1.25) + $4.00 = $38.10	$38.10	$23.96	$14.14
			TOTALS	**$626.70**	**$486.74**	**$139.96**

The total MAR for the services in dispute is $626.70. The respondent paid a total of $486.74; therefore the requestor is entitled to additional reimbursement in the amount of $139.96.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $139.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §§413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor, within 30 days of receipt of this Order, the amount of $139.96 plus applicable accrued interest pursuant to 28 Texas Administrative Code §134.130.

Authorized Signature

		April 5, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), **including a certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.